# Integrating care: Next steps to building strong and effective integrated care systems across England

## Response by the Royal College of Surgeons of England

**Do you agree that giving ICSs a statutory footing from 2022, alongside other legislative proposals, provides the right foundation for the NHS over the next decade?**

***Agree***

The Royal College of Surgeons of England ("the College") welcomes the opportunity to comment on NHS England's proposals for Integrated Care Systems (ICSs). The NHS faces a number of significant challenges, both short-term and long-term. It is vital that system reforms enable the health service to address these as effectively as possible.

Of particular concern to the College is the very large backlog of elective procedures – many of which are surgical interventions – created by the COVID-19 pandemic, on top of the already large waiting list that our "stop-start" model of surgical provision had created. NHS England's latest waiting times data showed that a total of 4.44 million patients were waiting for hospital treatment in October 2020, with 162,888 having waited longer than 52 weeks (this compares with 1,321 patients who had waited longer than a year in October 2019).

As summarised in a National Voices report documenting the patient's perspective of waiting for elective care ("Improving our understanding of the experience of waiting for elective care", February 2020), long waits have a range of negative impacts on patients. The common themes are pain, psychological distress, fears around deterioration in health, threats to employment and loss of income, and increasing lack of trust in care providers, contributing to an overwhelmingly negative picture of life described at its worst as being "on hold" or in a "no man's land". Prolonged waits for surgery risk further deterioration in patients' condition, which can mean more complex surgery then being required, and there will sadly be some instances where patients die whilst waiting for a procedure.

It is essential therefore that the proposed ICS reforms support efforts to reduce the backlog of surgery. The pandemic has shown that working across systems can help deliver better services and outcomes. For example, this approach has enabled Trusts to work together, providing "mutual aid" at times of extreme pressure, so that surgery can continue. By collaborating, Trusts have also been able to put agreements in place to designate certain hospitals in an area as surgical hubs – for instance in the North East – ensuring that capacity has continued to be available for high priority elective procedures. In London, system-level working has been crucial to establishing an elective recovery programme which utilises certain hospitals across the capital as hubs for specified types of surgical procedure. While the surgical hubs model is not a "one-size-fits-all" solution, it is a useful approach for some geographies, and for some surgical specialties.

As we look forward we are keen this spirit of co-operation is nurtured and supported, to retain the benefits of these developments and establish an approach to delivering surgical services which has patients' timely access to surgery at its core. The suspension of elective procedures which took place at the start of the pandemic was not a one-off event, and has also taken place in previous winters due to the impact of other infectious diseases such as

flu and norovirus. In future, the use of models such as surgical hubs can help ensure that it will be possible to maintain planned surgery through “normal” winters, and this is best managed at system-level.

The College is supportive of the direction of travel set out in the consultation, particularly the focus on greater collaboration between providers, and believes this will provide the right foundation for the NHS for the coming years. We also welcome the commitment to embed specialist clinical leadership across secondary and tertiary services within systems (paragraph 2.26). This should include surgeons, as it is crucial to ensure that their experience and the needs of surgical patients are reflected in decision-making. Equally, we are pleased that the consultation recognises the important role that existing clinical networks have to play – clinicians possess significant knowledge and expertise from many years of training and practice, so we should seek to make the most of this through the process of system reform and beyond.

Although the consultation focuses on the options for placing ICSs on a statutory footing, the College is particularly keen to stress that legislation on its own will not be enough to deliver a more integrated health system. In our experience of similar initiatives, involving changes to structures in both England and the devolved nations, wider cultural change in the way that organisations work together is equally important. Improved processes are needed to achieve true integration, for example policies that enable surgeons and their teams to work across different sites within an ICS, support flexible working and enable improved workforce and service planning. This hinges on effective sharing of data, and identifying and removing bureaucratic administrative hurdles that block collaboration. Section 2 of the consultation document provides an overview of the practical measures necessary to make the vision of ICSs a reality, and we would emphasise that these are just as (if not more) important than legislative change itself.

We saw how collaboration between clinicians and organisations during 2020 was key to keeping services going through the pandemic. Perversely, the crisis proved to be a very effective force for breaking down institutional and cultural barriers. We must retain and nurture this culture of collaboration to create a more integrated system, which makes smarter use of resources. To do so entails planning services on a population footprint that runs well beyond a single hospital Trust. Although changes to structures have a short-term cost because of the disruption brought about by change, over the longer term, if done well, they bring benefits to taxpayers in more efficient use of resources, and benefits to patients in improved access to high quality services.

It is also vital that we learn lessons from previous experience, for example around the implementation of Sustainability and Transformation Plans. The College believes that any mergers or concentration of services which take place as a result of the creation of ICSs must follow a transparent process and involve clinician engagement. Service reconfigurations in particular should be clinically-led, and based on what is clinically effective. Ensuring that any such changes make best use of a scarce workforce, and secure public and patient support, will clearly also be vital. In addition, new ICS arrangements must enable clinicians and wider teams to work across the entire system, and we should recognise the opportunities that integration provides in terms of education, training and continuing professional development. Furthermore, clarity around accountability and governance will be essential.

Lastly, the College is keen to emphasise that once an NHS organisation joins an ICS, it will be important that they continue to receive appropriate support from NHS England to address any specific challenges that they face, so that system reform does not come at the expense of an individual organisation's development.

**Do you agree that option 2 offers a model that provides greater incentive for collaboration alongside clarity of accountability across systems, to Parliament and most importantly, to patients?**

***Agree***

The College agrees that of the options put forward in the consultation, option 2 represents the best model for placing ICSs on a statutory footing. In our view this provides greater clarity for stakeholders than retaining the Clinical Commissioning Group architecture as proposed under option 1, and also means that no further primary legislation will be required to complete the reforms.

However, as we discuss in more detail in our response to the following question, even under option 2 wider questions will remain about how accountability and governance will work under the ICS system. Clarity on these issues will be extremely important if the reforms are to be successful.

**Do you agree that, other than mandatory participation of NHS bodies and Local Authorities, membership should be sufficiently permissive to allow systems to shape their own governance arrangements to best suit their populations needs?**

***Agree***

The College agrees that membership of ICSs must be sufficiently permissive to allow systems to shape their own governance arrangements, and recognises that this is an important part of enabling them to respond to the specific health needs of their local populations. We also believe it will be vital for clinicians to be involved in decision-making, and that ICSs should therefore formalise clinical participation.

Furthermore, as noted in our response to the previous question, there are outstanding questions around accountability and governance which the consultation does not address. In particular, there are a number of bodies that will prospectively be constituent members of ICSs who possess their own decision-making powers or have semi-autonomous status, such as local authorities and Foundation Trusts. It is not clear from the consultation where the boundaries between these bodies and an ICS will be set in terms of decision-making, or where lines of accountability will lie. If ICSs are to become statutory organisations it will be extremely important for there to be clarity around these issues and what the powers of an ICS will be.

In addition, we also note that given wider changes to England's public health infrastructure following the decision to close Public Health England, there is an inherent element of uncertainty around the position of public health within ICS systems. This is particularly significant in terms of preventative work, which the consultation identifies as an important priority for ICSs. Prevention is a particular concern of the College's Faculty of Dental

Surgery, since it is central to good oral health. Notably, public health strategies can reduce the number of children admitted to hospital for tooth extraction. The consultation suggests that “New powers will make it easier to form joint budgets with the local authority, including for public health functions” (paragraph 2.43), but further clarity around ICSs role in public health will ultimately be needed.

**Do you agree, subject to appropriate safeguards and where appropriate, that services currently commissioned by NHSE should be either transferred or delegated to ICS bodies?**

***Agree***

From the College’s perspective, what is ultimately important in terms of commissioning is that any new arrangements improve the provision of timely, high quality surgery for patients, across all specialties. Currently patients’ access to surgery varies hugely from region to region, and from specialty to specialty.

In principle the College is not opposed to the proposals to delegate commissioning powers to ICSs, recognising that this would be a key part of enabling them to address the particular healthcare needs of their local populations, and in view of the infrastructure and staff resource available to them. However, it is important to retain a degree of national oversight, to avoid the risk of increasing regional variation. NHS England should be able to delegate nationally commissioned services to the ICS level, providing that national accountability to standards remains. For example, we stress the importance of continued reporting at the national level against legal clinical standards (such as the 18 week referral-to-treatment clinical standard), and the ability of national policy-makers to ensure ICSs are adhering to national standards.

We recognise that delegating commissioning powers to ICSs will entail changes to the national tariff payment system. It will however be vital for any new funding mechanisms to continue to incentivise the timely provision of elective surgery (including specialist surgery), and promote and reward clinical best practice.

Specialised commissioning, which is discussed in detail in the consultation, is one example of where it will be essential to manage the shift from a national to localised approach effectively, so that standards are maintained. From a surgical perspective, certain highly complex but low volume procedures are best undertaken in specialist centres – not every area will have one of these, or the infrastructure to support such a service, meaning some element of national co-ordination will remain necessary so that patients can be referred across boundaries as necessary. It will be vital that under the ICS system, specialised commissioning is sufficiently flexible to enable these sorts of arrangements to continue, so we can ensure that all patients with complex conditions have equitable access to high quality specialist treatment.

**Contact**

To discuss any of the points raised in this response in more detail please contact the Policy and Public Affairs team at the Royal College of Surgeons of England at publicaffairs@rcseng.ac.uk